PERS Form **1C**

CHANGE OF INFORMATION

Retirement Plan (Check one) ☐ PERS ☐ MHSPRS ☐ MRS ☐ SLRP For PERS Use Only

Instructions: Please print or type in black ink. This form must be signed. Please complete the Member Information and Member Authorization sections and only the other sections where changes apply.

MEMBER INFORMATION (Must be completed in all cases)

SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/ccyy) / /

MEMBERSHIP STATUS

☐ MEMBER ☐ BENEFIT RECIPIENT (RETIREE OR BENEFICIARY)

NAME CHANGE/CORRECTION (Note: Employer certification of name change is required for **active** members to insure consistency in the name used for reporting PERS, Social Security, and W-2 wage information.)

CURRENT NAME FIRST	MI	LAST
PREVIOUS NAME FIRST	MI	LAST

EFFECTIVE DATE OF CHANGE (mm/dd/ccyy) / /

ADDRESS CHANGE/CORRECTION (new mailing address)

ADDRESS	HOME TELEPHONE NO ( )	
ADDRESS	BUSINESS TELEPHONE NO ( )	
CITY	STATE	ZIP CODE

EFFECTIVE DATE OF CHANGE (mm/dd/ccyy) / /

MARITAL STATUS CHANGE/CORRECTION and EFFECTIVE DATE OF CHANGE (mm/dd/ccyy)

☐ MARRIED / / ☐ DIVORCED / / ☐ WIDOWED / /

FAMILY INFORMATION CHANGE/CORRECTION

Please use additional Change Information Form if more than 4 dependent children. (This information is required to determine statutory benefits. Note, however, the designation of a beneficiary is on a separate form.)

SPOUSE NAME	SEX (M/F)	SSN	DATE OF BIRTH (mm/dd/ccyy)
DEPENDENT CHILDREN'S NAME(S)	SEX (M/F)	SSN	DATE OF BIRTH (mm/dd/ccyy)

MEMBER AUTHORIZATION

SIGNATURE OF MEMBER	DATE OF SIGNATURE (mm/dd/ccyy) / /

EMPLOYER CERTIFICATION

I hereby certify that the name change information provided above is consistent with the name used on the employer's records for reporting Social Security and IRS W-2 wage information.

AUTHORIZED SIGNATURE	DATE OF SIGNATURE (mm/dd/ccyy) / /
TITLE	TELEPHONE NUMBER ( )

BENEFIT CHANGE FORM

This form is NOT to be used for any COBRA event.
Use Benefit Termination Notice instead.

City of Gulfport
1410 24th Avenue
Gulfport, MS 39501
228.868.5831 office
228.868.5833 fax

GROUP NAME			GROUP NUMBER
City of Gulfport			Plan # ***08600***
EMPLOYEES LAST NAME	FIRST NAME	MIDDLE INITIAL	SOCIAL SECURITY NUMBER

(1) ☐ APPLICATION FOR ADDITION OF DEPENDENTS

(2) ☐ DELETION OF EMPLOYEE COVERAGE

(3) ☐ DELETION OF DEPENDENT COVERAGE: **Must have qualifying event and provide documentation, unless deletion is done during open enrollment.**

Please list dependents after checking this box.
Check appropriate Coverage box for each dependent.

EFFECTIVE DATE OF EVENT:_____

EFFECTIVE DATE OF ADDITION/DELETION: _____

CIRCLE TYPE OF EVENT

(A) For eligible spouse – give date of marriage
(B) For adopted child – give date of legal adoption or date appointed guardian – Attach copy of adoption or guardianship papers.
(C) For child acquired by marriage – give date of marriage.
(D) For birth of child – give date of birth and certificate of live birth (must be provided within 31 days of birth.
(E) For loss of Job/Coverage – give date of loss of job- Provide Certificate of Insurance

EMPLOYEE AND/OR DEPENDENT INFORMATION
COMPLETE FOR YOURSELF AND EACH DEPENDENT TO BE COVERED BY THE PLAN

FULL NAME	SEX M/F	DATE OF BIRTH MO	DAY	YEAR	SOCIAL SECURITY NUMBER	COVERAGE REQUESTED
EMPLOYEE						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
SPOUSE						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
CHILDREN 1.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
2.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
3.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
4.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
5.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision
6.						☐ Medical Only ☐ Dental 1500 ☐ Dental 2000 ☐ Vision

(4) ☐ CHANGE OF NAME: (must provide copy of social security card)	FROM:		TO:	
(5) ☐ CHANGE OF ADDRESS:	FROM:		TO:	
(6) ☐ TRANSFER TO NEW DIVISION:	FROM:		TO:	
(7) ☐ OTHER CHANGE TO RECORD:	FROM:		TO:	

Employee Signature:_____ Date Signed:_____

Personnel Use Only

Entered By: _____ Date Entered into MUNIS: _____

CHANGE OF PERSONAL INFORMATION

Fill in all applicable information and forward to Human Resources. Please print clearly.

Name:_____	**Social Security #:**_____
Employee #:_____	

NAME CHANGE

Name Changed to:_____

Reason for Name Change:_____

***Attach document supporting change.**

ADDRESS/PHONE CHANGE/EMAIL

New Address:_____
Street, P.O. Box, Apt. #, Route

_____
City State Zip

New Phone: (___)_____

If you would like to receive your paystub by email, please include your email address.

Email Address:_____

EMERGENCY CONTACT INFORMATION CHANGE

Name:_____ **Home Telephone:**_____

Relationship:_____ **Work Telephone:**_____

Personnel Use Only

Entered by:_____ Date entered into MUNIS:_____

Revised 1/2009